TIFFANY S. LEE, MD
4150 SNAPFINGER WOODS DR.
DECATUR, GA 30035
SUITE 100 A
404-286-7874 (PHONE)
404-286-7858 (FAX)
tleemd@strawbridgehealth.com (EMAIL)

MEMBER AGREEMENT

Whereas Member desires to join the membership service of Strawbridge Health (SH).

Whereas SH desires to provide preventive and maintenance healthcare services to member.

In consideration of the mutual covenants contained herein Member and SH agree as follows.

I. **I. Same day visits and walk-in appointments are not guaranteed.** We do our best to provide same day visits and walk in appointments; however sometimes it is not feasible. If we are unable to accommodate you on the same day, we will schedule the earliest possible appointment available.

II. **Emergency care.** If you are experiencing chest pain, shortness of breath, severe abdominal pain, uncontrolled blood sugar, unexplained episodes of passing out, severe headaches or uncontrolled pain and we **cannot** see you on the same day, you should report to the ER/Urgent Care and follow up with our office as soon as possible.

III. **Initial Registration is $35.00**

IV. **Subscription fee.**

A. **Individuals.** You agree to a one-time annual subscription fee for the **Silver Care Plan** of six-hundred forty-nine dollars ($649.00) which includes one month free or an automated monthly payment of fifty-nine dollars ($59.00) per month for twelve months for a total of seven hundred eight dollars ($708.00); **Gold Care Plan** one time annual membership fee of eight hundred sixty-nine dollars ($869.00) which includes one free month or an automated monthly payment of seventy-nine dollars ($79.00) per month for twelve months for a total of nine hundred forty-eight dollars ($948.00); or the **Platinum Care Plan** for one thousand eighty-nine dollars ($1,089) which includes one month free or an automated monthly payment of ninety-nine dollars ($99.00) for twelve months for a total of one thousand one hundred eighty-eight dollars ($1188.00).

B. **Companies/Employers.** The employer agrees for the **Silver Care Plan** of six-hundred forty-nine dollars dollars ($649.00) which includes one month free or an automated monthly payment of fifty-nine dollars ($59.00) per month for twelve months for a total of seven hundred eight dollars ($708.00); **Gold Care Plan** one time annual membership fee of eight hundred sixty-nine dollars ($869.00) which includes one free month or an automated monthly payment of seventy-nine dollars ($79.00) per month for twelve months for a total of nine hundred forty-eight dollars ($948.00); or the **Platinum Care Plan** for one thousand eighty-nine dollars ($1,089) which includes one month

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free or an automated monthly payment of ninety-nine dollars ($99.00) for twelve months for a total of one thousand one hundred eighty-eight dollars ($1188.00).

V.SH reserves the right to terminate any Member's membership for any reason.

PLEASE CIRCLE THE CARE PLAN OF CHOICE FOR MEMBERSHIP

SILVER PLAN: **$59/month**

GOLD PLAN: **$79/month**

PLATINUM PLAN: **$99/month**

WRITE IN THE PLAN FOR ANY SPECIAL PRICING: _____

With my signature below, I affirm that I have read and understand the contract/membership agreement of Strawbridge Health. Without limiting the scope of the Policies, I specifically agree to comply with the above policies and understand that the policies may be updated from time to time. I will be bound by the new policies unless I give Notice of Dissent within thirty (30) days of Notice of Policy Change:

Signature: _____ **Date: _____**

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PATIENTS RIGHTS AND RESPONSIBILITIES

As the patient, it is your responsibility to:

- Pay applicable fees at the time as outlined in your agreement.
- Adhere to the fifteen (15) minute grace period that we allow for late patients.
- Keep all scheduled appointments with our office and any appointments that are scheduled with specialists.
- Call in advance if you will not be able to keep an appointment.
- Follow up with the staff if you do not fully understand the course of your treatment.
- Provide the most accurate and complete information regarding present complaints, past illnesses, hospitalizations, medication, unexpected changes in your condition or any other health matters.
- Follow up on your provider's instructions, comply with your treatment plan, take medications as prescribed and ask questions concerning your healthcare.
- Inform our office of all medications and dosages you are currently taking or prescribed and ensure you call for refills BEFORE you exhaust prescriptions.

As a patient you have the right to:

- The Right to Be Treated with Respect
- The Right to Quality Care
- The Right to Make a Treatment Choice
- The Right to Refuse Treatment
- The Right to Obtain Your Medical Records
- The Right to Privacy of Your Medical Records

I affirm that I have read and understand the Patient's Rights and Responsibilities _____ (initial).

I affirm that I have read and understand the HIPPA POLICY. _____ (initial).

I affirm that I have received a copy of the SH MEMBER AGREEMENT._____ (initial)

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Date: _____

Patient Name: _____ Signature: _____

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PAYMENT CONSENT

Provide the credit/ debit card or bank account information for the automated monthly payment for the Strawbridge Health, LLC subscription service:

Credit / Debit Card (circle below)

Visa MasterCard Discover American Express

Last 4- digits of Account #: _____
Expiration Date: _____

Bank Account:
Name of Bank: _____
Name on Account: _____
Routing #: _____
Last 4-digits of Account #: _____

By signing below you are agreeing that you understand the following statements:

- I understand that SH requires a twelve (12) month commitment to its subscription service that all participants are expected to honor.
- I verify that my credit card information, provided above, is accurate to the best of my knowledge.
- I authorize SH to charge my credit/debit card or bank account for professional services every month for the period of twelve (12) months.
- I understand that if I do not wish to renew services from SH at the end of my annual subscription, I will submit written Notice of Withdrawal no later than 1st day of 12th month of your subscription.
- I understand that if I do not cancel by the 1st day of the 12th month, my subscription service will be automatically renewed.
- I understand that in the event my monthly payment is declined, I am responsible for a $35 fee in addition to the monthly fee for the subscription.
- I understand that if my payment is declined and an alternative payment is not made within thirty (30) days to bring my balance current, the remaining balance on the contract may be referred to collections.
- I understand that if my account is referred to collections, I will be responsible for the entire amount owed under the contract plus the costs of collections including any interest, attorney's fees, courts costs etc.

Signature: _____ **Date: _____**

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LAB FEES

I (patient name) _____ understand that labs are NOT included in the membership fee unless otherwise specified in the care plan. Costs of labs are heavily discounted, but they are not free of charge. I understand that I will be provided a list of the cost of labs that the physician recommends, and it is my choice whether to accept responsibility for the cost and proceed. I agree to pay for labs as a separate cost.

Date: _____

Patient Name: _____ Signature: _____